Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA Central Arkansas Veterans HCS - 598

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 456

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1000** (point-in-time estimate of homeless veterans in service area) **X 48%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 456** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	276	0
Transitional Housing Beds	201	0
Permanent Housing Beds	255	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Dental Care	Will continue to use Healthcare for the Homeless Services and River City Ministries.
Eye Care	Will continue to inform veterans of changes in eligibility for eye care at the VA. Will also refer to River City Ministries.
Long-term, permanent housing	Will continue working with the HUD Continuum of Care and the Jericho Coalition for permanent housing options.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 37 Non-VA staff Participants: 56%
Homeless/Formerly Homeless: 3%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.26	27%	2.34	2
2	Child care	2.53	3%	2.39	3
3	Legal assistance	2.72	10%	2.61	4
4	Help managing money	2.73	0%	2.71	7
5	Long-term, permanent housing	2.78	20%	2.25	1
6	Eye care	2.86	3%	2.65	5
7	Glasses	2.88	3%	2.67	6
8	Help with transportation	2.89	17%	2.82	11
9	Welfare payments	2.91	0%	2.97	16
10	Guardianship (financial)	3.09	0%	2.76	9
11	Emergency (immediate) shelter	3.14	17%	3.04	20
12	Education	3.25	3%	2.88	13
13	Family counseling	3.31	3%	2.85	12
14	Spiritual	3.33	7%	3.30	27
15	SSI/SSD process	3.37	0%	3.02	19
16	Job training	3.43	7%	2.88	14
17	Discharge upgrade	3.44	0%	2.90	15
18	Halfway house or transitional living facility	3.46	10%	2.76	8
19	Help with finding a job or getting employment	3.53	3%	3.00	17
20	Personal hygiene (shower, haircut, etc.)	3.65	3%	3.21	26
21	Food	3.65	17%	3.56	35
22	Help getting needed documents or identification	3.66	3%	3.16	23
23	Clothing	3.68	10%	3.40	31
24	Help with medication	3.69	0%	3.18	24
25	Women's health care	3.72	3%	3.09	21
26	Services for emotional or psychiatric problems	3.81	0%	3.20	25
27	Treatment for dual diagnosis	3.81	0%	3.01	18
28	Medical services	3.83	3%	3.55	34
29	Detoxification from substances	3.91	10%	3.11	22
30	VA disability/pension	3.94	7%	3.33	29
31	AIDS/HIV testing/counseling	3.95	0%	3.38	30
32	TB treatment	4	0%	3.45	33
33	Hepatitis C testing	4.03	0%	3.41	32
34	Drop-in center or day program	4.06	0%	2.77	10
35	TB testing	4.06	0%	3.58	36
36	Treatment for substance abuse	4.08	13%	3.30	28

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.29	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.74	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.63	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.65	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.66	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.53	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.23	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.38	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.58	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	3.09	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.88	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.31	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.97	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.52	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.9	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.03	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.61	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.29	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.48	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.39	1.84

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CHALENG 2004 Survey: VA Gulf Coast HCS - 520, Biloxi, MS, Pensacola, FL

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 86

2. Point-in-time estimate of Veterans who are Chronically Homeless: 24

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **86** (point-in-time estimate of homeless veterans in service area) **X 33%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 84%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 24** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	100	0
Transitional Housing Beds	0	15
Permanent Housing Beds	0	35

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Work with homeless coalition to develop transitional residential facility.
VA disability/pension	Work with homeless coalition to improve VA benefits application process.
Help with Transportation	Work with homeless coalition to contact public transportation sources to try to develop better access routes and times.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 14 Non-VA staff Participants: 29%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.2	60%	2.25	1
2	Halfway house or transitional living facility	2.22	50%	2.76	8
3	Help with transportation	2.3	10%	2.82	11
4	Child care	2.5	0%	2.39	3
5	Glasses	2.56	0%	2.67	6
6	Help managing money	2.78	0%	2.71	7
7	Legal assistance	2.9	0%	2.61	4
8	Emergency (immediate) shelter	3	10%	3.04	20
9	Family counseling	3	0%	2.85	12
10	Dental care	3	10%	2.34	2
11	Education	3	0%	2.88	13
12	Eye care	3.2	0%	2.65	5
13	Drop-in center or day program	3.3	10%	2.77	10
14	Job training	3.3	0%	2.88	14
15	Detoxification from substances	3.4	0%	3.11	22
16	Welfare payments	3.44	0%	2.97	16
17	Guardianship (financial)	3.44	0%	2.76	9
18	Treatment for dual diagnosis	3.5	0%	3.01	18
19	SSI/SSD process	3.56	0%	3.02	19
20	Discharge upgrade	3.56	0%	2.90	15
21	Personal hygiene (shower, haircut, etc.)	3.6	0%	3.21	26
22	Food	3.8	0%	3.56	35
23	Help with finding a job or getting employment	3.8	20%	3.00	17
24	VA disability/pension	3.9	0%	3.33	29
25	Clothing	3.91	0%	3.40	31
26	Help getting needed documents or identification	4	0%	3.16	23
27	Treatment for substance abuse	4.1	0%	3.30	28
28	Services for emotional or psychiatric problems	4.2	0%	3.20	25
29	Medical services	4.2	30%	3.55	34
30	AIDS/HIV testing/counseling	4.2	0%	3.38	30
31	Women's health care	4.3	0%	3.09	21
32	Help with medication	4.3	0%	3.18	24
33	Hepatitis C testing	4.3	0%	3.41	32
34	Spiritual	4.3	0%	3.30	27
35	TB testing	4.4	0%	3.58	36
36	TB treatment	4.4	0%	3.45	33

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.33	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	4.08	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.55	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.36	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.27	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.64	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.8	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.75	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.43	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.38	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.86	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.57	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.57	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.43	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.8	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.67	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.57	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.83	1.84

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CHALENG 2004 Survey: VAMC Alexandria, LA - 502

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 2040

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1023

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **2040** (point-in-time estimate of homeless veterans in service area) **X 59%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 86%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1023** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	693	60
Transitional Housing Beds	327	100
Permanent Housing Beds	913	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 9

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Aftercare Ministries opened this year and was able to provide some emergency shelter placement to recently released homeless veteran inmates. However, the facility is operating at full capacity now. Upcoming plans include recommending local homeless coalition pursue more emergency shelter facilities.
Transitional living facility	A transitional living home sponsored by City of Alexandria Inner City Revitalization Corporation may open in 2005. The organization has secured the building and properties, and some renovation funds.
Drop-in Center or Day Program	No current plans exist for drop-in center nor a day program. VA Healthcare for Homeless Veterans staff will encourage local community leaders to consider plans for proposing the development of a local drop-in center as a point-of-contact for other services to the homeless population in Central Louisiana.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 94 Non-VA staff Participants: 66% Homeless/Formerly Homeless: 38%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.19	22%	2.34	2
2	Child care	2.33	3%	2.39	3
3	Long-term, permanent housing	2.45	22%	2.25	1
4	Glasses	2.49	3%	2.67	6
5	Legal assistance	2.53	4%	2.61	4
6	Drop-in center or day program	2.54	5%	2.77	10
7	Family counseling	2.61	0%	2.85	12
8	Eye care	2.62	11%	2.65	5
9	Discharge upgrade	2.68	1%	2.90	15
10	Help with finding a job or getting employment	2.7	6%	3.00	17
11	Treatment for dual diagnosis	2.72	9%	3.01	18
12	Guardianship (financial)	2.73	1%	2.76	9
13	Halfway house or transitional living facility	2.74	20%	2.76	8
14	Job training	2.78	3%	2.88	14
15	Education	2.84	5%	2.88	13
16	Help managing money	2.87	3%	2.71	7
17	Welfare payments	2.88	0%	2.97	16
18	Emergency (immediate) shelter	2.89	27%	3.04	20
19	Women's health care	2.89	0%	3.09	21
20	SSI/SSD process	3	1%	3.02	19
21	Help with transportation	3.01	5%	2.82	11
22	Services for emotional or psychiatric problems	3.11	4%	3.20	25
23	TB treatment	3.11	0%	3.45	33
24	Help getting needed documents or identification	3.17	0%	3.16	23
25	VA disability/pension	3.22	13%	3.33	29
26	Help with medication	3.26	1%	3.18	24
27	Personal hygiene (shower, haircut, etc.)	3.28	4%	3.21	26
28	TB testing	3.33	0%	3.58	36
29	Hepatitis C testing	3.34	1%	3.41	32
30	Detoxification from substances	3.36	0%	3.11	22
31	Clothing	3.37	1%	3.40	31
32	AIDS/HIV testing/counseling	3.42	1%	3.38	30
33	Treatment for substance abuse	3.49	9%	3.30	28
34	Food	3.5	4%	3.56	35
35	Spiritual	3.51	4%	3.30	27
36	Medical services	3.64	5%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.93	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.5	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.98	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.96	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.84	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.99	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.76	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.67	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.57	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.17	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.6	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.08	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.9	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.17	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.19	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.11	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.97	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.88	1.84

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CHALENG 2004 Survey: VAMC Fayetteville, AR - 564

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 110

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **500** (point-in-time estimate of homeless veterans in service area) **X 23%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 94%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 110** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	200	0
Transitional Housing Beds	49	20
Permanent Housing Beds	72	40

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	H.O.U.S.E., inc. in Joplin, Missouri, has completed a 12-bed expansion for veterans. They will apply again for VA Grant and Per Diem funding. Ten-bed VA Healthcare for Homeless Veterans contract in place. Continue work closely with Quality Life Associates with expansion of their 5-bed facility in Fayetteville, Arkansas.
Treatment for substance abuse	VAMC-Fayetteville, AR has a new STS-OPT 28-day substance abuse program with OPT follow-up available. Veteran can be detoxified and receive 28-day rehabilitation. VA homeless referral is made to housing after completion of treatment. HCHV and SAC Staff will continue to work together with the homeless needing substance abuse treatment.
Help with Transportation	H.O.U.S.E., Inc. in Joplin, Missouri, has again written for a van grant through the VA Grant Per Diem. Quality Life Associates facility provides transportation for their veteran residents. Ozark regional transit provides shuttle/trolley services for a minimal fee. The University of Arkansas has a free bus service in Fayetteville, AR. Rural areas and little funding hampers this area. H.O.U.S.E., Inc. provides van services for veterans along with DAV vans in the service area.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 15 Non-VA staff Participants: 93%
Homeless/Formerly Homeless: 7%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.8	57%	2.25	1
2	Dental care	1.93	0%	2.34	2
3	Child care	2.07	0%	2.39	3
4	Job training	2.4	14%	2.88	14
5	Legal assistance	2.4	7%	2.61	4
6	Halfway house or transitional living facility	2.47	43%	2.76	8
7	Guardianship (financial)	2.6	0%	2.76	9
8	Help with finding a job or getting employment	2.6	14%	3.00	17
9	Eye care	2.67	0%	2.65	5
10	Detoxification from substances	2.8	0%	3.11	22
11	Treatment for dual diagnosis	2.8	7%	3.01	18
12	Help managing money	2.8	0%	2.71	7
13	Emergency (immediate) shelter	2.87	21%	3.04	20
14	Family counseling	2.87	0%	2.85	12
15	Glasses	2.93	0%	2.67	6
16	Help with transportation	2.93	14%	2.82	11
17	Treatment for substance abuse	3	7%	3.30	28
18	Services for emotional or psychiatric problems	3.07	14%	3.20	25
19	SSI/SSD process	3.07	0%	3.02	19
20	AIDS/HIV testing/counseling	3.13	0%	3.38	30
21	Help getting needed documents or identification	3.13	0%	3.16	23
22	Drop-in center or day program	3.2	0%	2.77	10
23	Education	3.2	0%	2.88	13
24	Discharge upgrade	3.23	0%	2.90	15
25	Women's health care	3.27	0%	3.09	21
26	Welfare payments	3.27	0%	2.97	16
27	Hepatitis C testing	3.4	0%	3.41	32
28	Spiritual	3.53	0%	3.30	27
29	TB treatment	3.57	0%	3.45	33
30	Personal hygiene (shower, haircut, etc.)	3.6	0%	3.21	26
31	Medical services	3.6	0%	3.55	34
32	VA disability/pension	3.64	0%	3.33	29
33	Food	3.67	0%	3.56	35
34	Help with medication	3.67	0%	3.18	24
35	Clothing	3.73	0%	3.40	31
36	TB testing	3.73	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.93	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.53	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.27	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.53	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.13	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.13	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.87	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.53	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.64	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.15	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.14	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.36	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.29	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.36	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.5	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.93	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.5	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.43	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.43	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.64	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Houston, TX - 580

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 3500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 571

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **3500** (point-in-time estimate of homeless veterans in service area) **X 20%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 81%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 571** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	800	1500
Transitional Housing Beds	250	250
Permanent Housing Beds	350	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 6

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Collaborative effort with US Vets initiative to provide housing for 54 disabled homeless veterans. Houston VA is exploring options and possibility of establishing a domiciliary.
Immediate shelter	US Vets collaboration to establish 30-day substance abuse program through VA Grant and Per Diem funding.
Treatment for substance abuse	Salvation Army awarded VA Grant and Per Diem and will begin substance abuse program providing 30 beds.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 25 Non-VA staff Participants: 72% Homeless/Formerly Homeless: 28%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.5	0%	2.39	3
2	Detoxification from substances	2.58	0%	3.11	22
3	Long-term, permanent housing	2.68	32%	2.25	1
4	Halfway house or transitional living facility	2.75	28%	2.76	8
5	Dental care	2.79	20%	2.34	2
6	Legal assistance	2.81	0%	2.61	4
7	Guardianship (financial)	2.9	0%	2.76	9
8	Treatment for substance abuse	2.96	32%	3.30	28
9	Drop-in center or day program	3	0%	2.77	10
10	Eye care	3	12%	2.65	5
11	Treatment for dual diagnosis	3.04	0%	3.01	18
12	Welfare payments	3.04	0%	2.97	16
13	Discharge upgrade	3.04	0%	2.90	15
14	Women's health care	3.05	4%	3.09	21
15	SSI/SSD process	3.09	4%	3.02	19
16	Education	3.09	4%	2.88	13
17	Help managing money	3.1	8%	2.71	7
18	Emergency (immediate) shelter	3.13	28%	3.04	20
19	Family counseling	3.14	0%	2.85	12
20	Help with transportation	3.17	0%	2.82	11
21	Glasses	3.22	4%	2.67	6
22	Help getting needed documents or identification	3.29	0%	3.16	23
23	Job training	3.33	4%	2.88	14
24	Clothing	3.36	0%	3.40	31
25	Services for emotional or psychiatric problems	3.38	4%	3.20	25
26	Help with finding a job or getting employment	3.43	4%	3.00	17
27	Spiritual	3.45	0%	3.30	27
28	TB treatment	3.5	0%	3.45	33
29	Help with medication	3.52	0%	3.18	24
30	Personal hygiene (shower, haircut, etc.)	3.56	0%	3.21	26
31	Food	3.63	0%	3.56	35
32	VA disability/pension	3.67	4%	3.33	29
33	Hepatitis C testing	3.68	4%	3.41	32
34	AIDS/HIV testing/counseling	3.71	0%	3.38	30
35	Medical services	3.88	0%	3.55	34
36	TB testing	3.92	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.28	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.68	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.36	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.32	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.2	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.04	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.96	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.94	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.94	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.13	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.13	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.27	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.93	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.27	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.27	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.27	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.57	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Jackson, MS - 586

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 272

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1000** (point-in-time estimate of homeless veterans in service area) **X 29%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 95%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 272** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	1741	100
Transitional Housing Beds	882	100
Permanent Housing Beds	125	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Support HUD funding requests/other grant proposals for various local agencies: Country Oaks Recovery Center, Pine Grove Green Meadows Project, Partners to End Homelessness, and Mississippi United to End Homelessness Coalition.
Dental Care	Those who qualify under VHA Directive 2002-080 continue to receive excellent, comprehensive dental care at this VA. Other veterans continue to be referred to other community resources.
Transitional living facility	With addition of new VA Per Diem program, Pinebeth Mental Health Resources Veterans Education and Treatment have additional 20 beds for veterans.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 57 Non-VA staff Participants: 92%
Homeless/Formerly Homeless: 37%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.65	53%	2.25	1
2	Child care	2.09	4%	2.39	3
3	Dental care	2.35	30%	2.34	2
4	Legal assistance	2.36	0%	2.61	4
5	Drop-in center or day program	2.43	9%	2.77	10
6	Help with transportation	2.55	11%	2.82	11
7	Guardianship (financial)	2.62	2%	2.76	9
8	Eye care	2.68	6%	2.65	5
9	Help managing money	2.71	0%	2.71	7
10	Job training	2.77	8%	2.88	14
11	Halfway house or transitional living facility	2.8	15%	2.76	8
12	Glasses	2.82	4%	2.67	6
13	Welfare payments	2.91	0%	2.97	16
14	SSI/SSD process	2.94	6%	3.02	19
15	Discharge upgrade	2.94	2%	2.90	15
16	Women's health care	2.98	0%	3.09	21
17	Education	3.02	0%	2.88	13
18	Family counseling	3.06	2%	2.85	12
19	Help getting needed documents or identification	3.09	0%	3.16	23
20	Help with finding a job or getting employment	3.16	8%	3.00	17
21	Emergency (immediate) shelter	3.24	2%	3.04	20
22	Spiritual	3.32	2%	3.30	27
23	Personal hygiene (shower, haircut, etc.)	3.42	0%	3.21	26
24	VA disability/pension	3.46	6%	3.33	29
25	Detoxification from substances	3.47	2%	3.11	22
26	Help with medication	3.52	4%	3.18	24
27	Hepatitis C testing	3.53	2%	3.41	32
28	AIDS/HIV testing/counseling	3.54	4%	3.38	30
29	Clothing	3.65	0%	3.40	31
30	Services for emotional or psychiatric problems	3.7	4%	3.20	25
31	Treatment for substance abuse	3.71	6%	3.30	28
32	Medical services	3.71	6%	3.55	34
33	Treatment for dual diagnosis	3.76	2%	3.01	18
34	Food	3.77	2%	3.56	35
35	TB testing	3.86	0%	3.58	36
36	TB treatment	3.86	0%	3.45	33

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.82	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.24	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.22	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.04	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.04	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.12	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.04	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.82	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.51	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.97	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.97	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.31	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.71	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.6	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.54	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.91	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.51	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.57	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.48	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.82	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC New Orleans, LA - 629

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 2700

2. Point-in-time estimate of Veterans who are Chronically Homeless: 492

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **2700** (point-in-time estimate of homeless veterans in service area) **X 19%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 98%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 492** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	400	0
Transitional Housing Beds	295	50
Permanent Housing Beds	10	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Plan is to pursue more Section 8 housing vouchers with local housing authorities. VA Supported Housing team plans to continue pursuing affordable housing in private housing sector.
Transitional living facility	Plan is to continue announcing notices of funding availability to interested providers, especially for VA Grant and Per Diem funding.
Immediate shelter	There is a need for more funds for shelter vouchers since most shelters in the New Orleans area cost $6 or more per night.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 33 Non-VA staff Participants: 94% Homeless/Formerly Homeless: 15%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Child care	2.31	0%	2.39	3
2	Discharge upgrade	2.52	3%	2.90	15
3	Long-term, permanent housing	2.62	27%	2.25	1
4	Clothing	2.74	7%	3.40	31
5	Help managing money	2.74	0%	2.71	7
6	Personal hygiene (shower, haircut, etc.)	2.77	20%	3.21	26
7	Emergency (immediate) shelter	2.77	20%	3.04	20
8	Family counseling	2.77	0%	2.85	12
9	Job training	2.77	7%	2.88	14
10	Detoxification from substances	2.81	3%	3.11	22
11	Treatment for dual diagnosis	2.82	3%	3.01	18
12	Help with finding a job or getting employment	2.87	7%	3.00	17
13	Halfway house or transitional living facility	2.9	23%	2.76	8
14	Drop-in center or day program	2.9	13%	2.77	10
15	Guardianship (financial)	2.94	3%	2.76	9
16	Spiritual	2.97	10%	3.30	27
17	Food	3	3%	3.56	35
18	Help with transportation	3	3%	2.82	11
19	Education	3	0%	2.88	13
20	Services for emotional or psychiatric problems	3.03	7%	3.20	25
21	Dental care	3.03	3%	2.34	2
22	Welfare payments	3.03	0%	2.97	16
23	Legal assistance	3.03	3%	2.61	4
24	Help with medication	3.06	0%	3.18	24
25	Glasses	3.07	0%	2.67	6
26	Women's health care	3.13	3%	3.09	21
27	Eye care	3.13	0%	2.65	5
28	Help getting needed documents or identification	3.13	7%	3.16	23
29	Hepatitis C testing	3.14	0%	3.41	32
30	Treatment for substance abuse	3.16	13%	3.30	28
31	SSI/SSD process	3.16	0%	3.02	19
32	AIDS/HIV testing/counseling	3.21	0%	3.38	30
33	TB testing	3.35	0%	3.58	36
34	TB treatment	3.37	0%	3.45	33
35	Medical services	3.55	0%	3.55	34
36	VA disability/pension	3.63	10%	3.33	29

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.36	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.09	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.38	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.75	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.39	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.68	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.16	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.09	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.13	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.83	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.93	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.03	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.67	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.67	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.83	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.93	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.69	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.55	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.86	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Oklahoma City, OK - 635

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 2,639

2. Point-in-time estimate of Veterans who are Chronically Homeless: 861

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **2,639** (point-in-time estimate of homeless veterans in service area) **X 34%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 96%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 861** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	400	0
Transitional Housing Beds	230	0
Permanent Housing Beds	0	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Issues of long-term, permanent housing are being addressed on the state level by the newly appointed Governor's Interagency Council on Homelessness resulting from the Policy Academy and Identified Action Plan.
Treatment for substance abuse	The VA has a substance abuse program that is active and well utilized by local veterans. The local detoxification facility doesn't often have a referral plan and we will address that.
Medical Services	We have been coordinating more with local free clinic "Healing Hands" to provide better range of health care services for homeless veterans.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 18 Non-VA staff Participants: 94%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.55	11%	2.25	1
2	Child care	1.75	0%	2.39	3
3	Job training	1.8	22%	2.88	14
4	Women's health care	1.88	0%	3.09	21
5	Education	1.88	0%	2.88	13
6	Treatment for dual diagnosis	1.89	11%	3.01	18
7	Dental care	1.9	0%	2.34	2
8	Family counseling	2	0%	2.85	12
9	Help managing money	2	0%	2.71	7
10	Legal assistance	2	0%	2.61	4
11	Services for emotional or psychiatric problems	2.1	0%	3.20	25
12	Drop-in center or day program	2.11	0%	2.77	10
13	Treatment for substance abuse	2.18	11%	3.30	28
14	Help with finding a job or getting employment	2.2	33%	3.00	17
15	Help with medication	2.22	0%	3.18	24
16	SSI/SSD process	2.22	22%	3.02	19
17	Guardianship (financial)	2.25	0%	2.76	9
18	Discharge upgrade	2.25	0%	2.90	15
19	Detoxification from substances	2.3	0%	3.11	22
20	Help with transportation	2.3	22%	2.82	11
21	Eye care	2.33	0%	2.65	5
22	Glasses	2.33	0%	2.67	6
23	Welfare payments	2.38	11%	2.97	16
24	Halfway house or transitional living facility	2.42	11%	2.76	8
25	Medical services	2.55	0%	3.55	34
26	Help getting needed documents or identification	2.56	0%	3.16	23
27	Spiritual	2.63	11%	3.30	27
28	Hepatitis C testing	2.88	11%	3.41	32
29	Personal hygiene (shower, haircut, etc.)	2.89	0%	3.21	26
30	AIDS/HIV testing/counseling	3	0%	3.38	30
31	Food	3.11	0%	3.56	35
32	Clothing	3.11	0%	3.40	31
33	VA disability/pension	3.22	0%	3.33	29
34	Emergency (immediate) shelter	3.25	22%	3.04	20
35	TB testing	3.44	0%	3.58	36
36	TB treatment	3.67	0%	3.45	33

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.93	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.77	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.36	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.08	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.36	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.92	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.33	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.5	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.8	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.45	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.08	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.58	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.67	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.92	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.55	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.4	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.55	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.58	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Shreveport, LA - 667

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 100

2. Point-in-time estimate of Veterans who are Chronically Homeless: 25

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **100** (point-in-time estimate of homeless veterans in service area) **X 26%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 97%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 25** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	200	15
Transitional Housing Beds	88	40
Permanent Housing Beds	20	40

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to work with housing authority with the HUD Shelter Plus Care Program. Continue to look for housing opportunities in community. Continue to have participants save money for housing while in program.
Transitional living facility	Continue working with Beacon House (currently have 32 veterans in level 2 case management there). Continue working with MCH Hotel (SRO). Continue to look for other housing options in the community.
Dental Care	Continue to refer clients to dental after 60 days in VA Healthcare for Homeless Veterans Program. MC New has a new dentist which should make time shorter for care. Get severe, acute cases fee-based out to community. Continue to work with David Raines Community Dental Clinic and Affordable Dentures.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 67 Non-VA staff Participants: 57% Homeless/Formerly Homeless: 36%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	2.16	20%	2.34	2
2	Child care	2.34	2%	2.39	3
3	Legal assistance	2.37	2%	2.61	4
4	Help managing money	2.45	2%	2.71	7
5	Glasses	2.52	2%	2.67	6
6	Long-term, permanent housing	2.54	24%	2.25	1
7	Guardianship (financial)	2.54	2%	2.76	9
8	Eye care	2.6	6%	2.65	5
9	Education	2.64	6%	2.88	13
10	Drop-in center or day program	2.72	2%	2.77	10
11	Welfare payments	2.72	2%	2.97	16
12	Family counseling	2.75	0%	2.85	12
13	SSI/SSD process	2.77	6%	3.02	19
14	Job training	2.79	11%	2.88	14
15	Discharge upgrade	2.88	2%	2.90	15
16	Help with finding a job or getting employment	2.9	9%	3.00	17
17	Treatment for dual diagnosis	2.97	9%	3.01	18
18	Help with transportation	3	6%	2.82	11
19	VA disability/pension	3.02	7%	3.33	29
20	Clothing	3.08	6%	3.40	31
21	Help getting needed documents or identification	3.09	4%	3.16	23
22	Services for emotional or psychiatric problems	3.18	9%	3.20	25
23	Women's health care	3.18	2%	3.09	21
24	Detoxification from substances	3.2	4%	3.11	22
25	Help with medication	3.21	4%	3.18	24
26	Emergency (immediate) shelter	3.23	6%	3.04	20
27	Halfway house or transitional living facility	3.24	20%	2.76	8
28	Personal hygiene (shower, haircut, etc.)	3.26	2%	3.21	26
29	Treatment for substance abuse	3.28	6%	3.30	28
30	Hepatitis C testing	3.34	0%	3.41	32
31	Food	3.35	7%	3.56	35
32	Medical services	3.5	2%	3.55	34
33	Spiritual	3.51	4%	3.30	27
34	AIDS/HIV testing/counseling	3.56	7%	3.38	30
35	TB treatment	3.56	0%	3.45	33
36	TB testing	3.71	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.12	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.85	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.71	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.79	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.66	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.79	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.65	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.8	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.37	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.38	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.48	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.13	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.82	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.08	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.44	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.92	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.87	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.05	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.14	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Muskogee, OK-623 (Tulsa, OK)

VISN 16

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 250

2. Point-in-time estimate of Veterans who are Chronically Homeless: 39

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **250** (point-in-time estimate of homeless veterans in service area) **X 20%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 75%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 39** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	600	0
Transitional Housing Beds	10	80
Permanent Housing Beds	0	5

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 4

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	The National Coalition for Homeless Veterans provided a resource workshop to local agencies on how to access VA Grant and Per Diem funds. At least one agency will attempt to apply for these funds.
Job Training	Will continue to refer to HVRP program and will also being to make referrals to Upward Bound Program through state.
Treatment for substance abuse	Will work with existing VA Healthcare for Homeless Veterans contract provider (12 and 12, Inc.) to determine if they are interested in VA Grant and Per Diem funds.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 26 Non-VA staff Participants: 85%
Homeless/Formerly Homeless: 4%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.8	41%	2.34	2
2	Long-term, permanent housing	2	41%	2.25	1
3	SSI/SSD process	2.52	5%	3.02	19
4	Help managing money	2.52	5%	2.71	7
5	Halfway house or transitional living facility	2.54	14%	2.76	8
6	Eye care	2.56	5%	2.65	5
7	Glasses	2.58	0%	2.67	6
8	Guardianship (financial)	2.63	0%	2.76	9
9	Treatment for dual diagnosis	2.65	0%	3.01	18
10	Education	2.68	0%	2.88	13
11	Treatment for substance abuse	2.69	14%	3.30	28
12	Legal assistance	2.7	5%	2.61	4
13	Detoxification from substances	2.81	14%	3.11	22
14	Services for emotional or psychiatric problems	2.85	5%	3.20	25
15	Child care	2.86	0%	2.39	3
16	Help with transportation	2.88	0%	2.82	11
17	Family counseling	2.92	0%	2.85	12
18	Discharge upgrade	2.92	0%	2.90	15
19	Help with medication	2.96	0%	3.18	24
20	Welfare payments	2.96	0%	2.97	16
21	Hepatitis C testing	3.08	9%	3.41	32
22	AIDS/HIV testing/counseling	3.12	0%	3.38	30
23	Job training	3.17	5%	2.88	14
24	Women's health care	3.19	0%	3.09	21
25	Help getting needed documents or identification	3.2	0%	3.16	23
26	VA disability/pension	3.23	5%	3.33	29
27	Medical services	3.27	5%	3.55	34
28	Help with finding a job or getting employment	3.28	5%	3.00	17
29	Spiritual	3.46	9%	3.30	27
30	Drop-in center or day program	3.54	0%	2.77	10
31	Personal hygiene (shower, haircut, etc.)	3.81	0%	3.21	26
32	TB treatment	3.81	0%	3.45	33
33	Emergency (immediate) shelter	3.83	5%	3.04	20
34	TB testing	3.96	0%	3.58	36
35	Clothing	4.04	9%	3.40	31
36	Food	4.27	9%	3.56	35

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.27	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.27	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.65	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.81	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.69	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.6	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.44	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.79	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.35	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.95	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.33	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.75	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.75	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.67	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.25	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.63	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.88	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.75	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84